DOCUMENT RESUME

ED 336 486 UD 028 242

AUTHOR Feng, Jianhua
TITLE Assessing the Culturally Different: Cultural Factors in the Clinical Assessment of Asian-Americans.
PUB DATE 91
NOTE 10p.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adjustment (to Environment); *Asian Americans; Chinese Americans; *Clinical Diagnosis; *Cultural Differences; Cultural Influences; Culture Fair Tests; Diagnostic Tests; Ethnic Bias; Ethnic Groups; *Evaluation Problems; Minority Groups; *Personality Assessment; Psychological Evaluation; *Psychological Testing; Racial Differences; Testing Problems

ABSTRACT

The impact of cultural variables on the clinical and personality assessment of Asian Americans is discussed, with emphasis on Chinese Americans. Any assessment procedures must take into account the diversity of Asian Americans, who belong to more than 29 distinct subgroups that are heterogeneous in language, religion, custom, degree of acculturation, and socioeconomic status. Asian Americans have generally been inadequately represented in normative samples of standardized traits, resulting in a negative framework that labels Asian Americans globally and interprets differences from the norm as deficits in ability or character. Cultural values can affect the thematic values of tests and clinical interviews, as well as perception. Clinicians who differ in language or culture from their clients may encounter difficulties in assessment, including difficulties in translation. Diagnosis should move from the delineation of trait and typology toward becoming a tool for intervention. Cultural views must be understood as they affect adaptation and the development of cognitive and emotional skills. An 11-item list of references is included. (SLD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Assessing the Culturally Different: Cultural Factors in the Clinical Assessment of Asian-Americans

Jianhua Feng

Memphis State University

ED336486

UD028242

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Jianhua Feng
Memphis State University

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

Assessing the Culturally Different: Cultural Factors in the Clinical Assessment of Asian-Americans

Jianhua Feng
Memphis State University

In recent years, clinical theory and practice have been subject to increasing criticism as not only irrelevant to the needs of ethnic minorities but also discriminatory. Misdiagnosis, overestimation, underestimation, or neglect of psychopathology are frequent problems when clinician and patient come from different cultures (Westermeyer, 1987). These problems are particularly apparent when assessment instruments have not been stansardized or validated on these groups and when the ethnic individuals are markedly different from mainstream Americans (Brislin, Lonner, & Thorndike, 1973). However, assessment must proceed. The clinician who encounters a culturally dissimilar client often has to make an evaluation of the client; researchers interested in cross-cultural comparisons frenquently must use psychological tests; and the mental health planners or administrators need to evaluate the well-being of all Americans (Sue & Sue, 1987). This paper discusses the impact of cultural variables on the clinical and personality assessment of Asian-Americans, in particular Chinese-Americans.

Asian-Americans encompass a number of highly diverse groups, including those of the Cambodian, Chinese, East Indian, Filipino, Guamanian, Hawaiian, Hmong, Indonesian, Japanese, Korean, Laotian, Samoan, and Vietnamese heritages. They in toto constitute the fastest growing minority groups in the United States. From 1970 to 1980, the

Asian population increased by approximately 143 percent (Pang, 1990). The rapid growth and change in population indicates the necessity to anticipate continuing problems associated with socio-emotional stress, language skills, unemployment, and education (Sue & Sue, 1987). Composed of more than 29 distinct subgroups, Asian-Americans are also quite heterogenous in language, religion, custom, socioeconomic status, and degree of acculturation. Such factors must be taken into consideration for any assessment.

Diagnosis has been stressed as a tool for intervention rather than as a labling process, yet this has to be applied to work with Asian-Americans. Research with Asian-Americans continues to emphasize the delineation of typologies or generalized traits in comparison with "Caucasian counterparts". The deviation of these traits from observed behavior is often based on the different cultural world views and value orientations of the researcher. Consequently, differences tend to be interpreted as negative traits or character deficits. For example, the Asian culture, in particular the Chinese culture emphasizes humility, modesty, treating oneself strictly while treating others more leniently; obligation to family, conformity, obedience, and subordination to authority, and inhibition of strong feelings; Asian-Americans have thus been "defined" as less dominant, aggressive, and autonomous; more introverted; less verbal; and more alienated than their Caucasian counterparts (Chin, 1983; White & Chan, 1983).

Although it is clear that a normative framework is critical to the diagnostic process, Asian-Americans have generally been inadequately represented in most normative samples of standardized traits. The consequence of these generalized psychological traits has been the

development of a negative framework that globally labels Asian-Americans, and interprets differences from white middle-class norms as deficits in innate ability or character. The generalization of these differences to clinical practice has had the unfortunate consequences of underestimating intellectual potential, generating misdiagnoses, justifying the absence of services, and limiting the diversity of treatment alternatives considered useful to Asian-Americans.

Over the years, according to Sue and Sue (1987), some studies have suggested that Asian-Americans have low rates of psychopathology; others have suggested high rates of psychopathology. The inconsistencies are largely due to cultural influences in the study of Asian-Americans. There has also been generally a low utilization rate of mental health and psychoeducational services among Asian-Americans. As Sue (1981) points out, the low rates of psychiatric hospitalization and juvenile delinquency likely reflect cultural values and not low rate of psychopathology. Public admission of personal problems may be difficult for many Asian-Americans because such admission might bring shame on the family. When mental health problems exist, Asian-Americans tend to express them via physical complaints.

It has become obvious that the clinical assessment is influenced by cultural factors, therefore, diagnostic criteria must examine the adaptive value of observed cognitive and emotional behavior in the context of the sociocultural history and the value system of the particular cultural group. Diagnostic process must start from the cultural frame of reference of the person being evaluated to minimize the bias of diagnosticians. In clinical assessment practice however, the definition of adaptive personality functioning for Asian-Americans still seems to emphasize

superficial stereotypic traits, acculturation, and marginality. Personality assessment should emphasize the uniqueness of the individual and the diversity of Asian-American groups in the context of cultural views and values, and the socialcultural milieu.

While respect for authority, filial piety, and shame are three "traits" commonly identified as valued and socially functional in the Asian culture, however, they have often been perceived by Westerners as negative ones reflecting self-debasement and rigidity; and these traits are often seen as interfering with the therapeutic process because they inhibit self-disclosure and open communication with authority figures, such as therapists. This may be true of some individuals, but their positive and facilitative functions need to be explored. Is shame, for example, reflective of the individuals' sense of social responsibility rather than self-debasement? Is the emphasis on filial piety and respect for authority reflective of the individuals' internalization of superego ideals and social reciprocity rather than passivity and dependency needs?

Since cultural world views influence how people organize and perceive their world, variations would be expected in thematic content on personality tests and clinical interviews. According to Chin (1983), on the Thematic Apperception Test, themes related to shame and authority figures appear qualitatively different and with greater frequency among Chinese-Americans. This may be interpreted as reflecting conflict over authority, it might also reflect different cultural ideals and adaptive solutions to conflict situations. Chin (1983) compared some classic Chinese and Western children's stories and found striking cultural differences. Chinese children's stories frequently emphasize the highly valued ego and superego traits of cleverness, filial piety, and scholarly industriousness. Outcomes frequently involve moral dilemmas in which

the parent wins over the child in conflic situations, and the benevolence of the authority figure is emphasized. Western stories tend to emphasize the sexual and aggressive impulses of the child, the gratification of these impulses and moral dilemmas in which the child wins over the "bad" parent in conflict situations.

Cultural values influencing perception can also be examplified in the interpretation of the Rorschach personality test. The cultural value placed on a holistic approach in the Asian culture, in contrast to the emphasis on details in the American culture, has been empirically supported. In studies using Rorschach test with Samoans and Chinese (Abel & Hsu, 1949; Cook, 1942), whole percepts were given more frequently. Similarly, the significance of color is different in the Chinese culture. Red color is highly valued as symbolic of happiness, prosperity, and celebration. White, while symbolic of purity, is also used for funerals. In contrast, red has negative connotations of anger, aggression, and sexual impuses in the American culture (Chin,1983). How Rorschach responses using color are interpreted given these differences is an important diagnostic consideration.

As part of culture, language also reflects culture. Clinicians who differ in culture or language from clients may encounter difficulties in face-to-face relationship, because assessment relies heavily on verbal communication and proficiency in English. Unfortunately, many Asian immigrants and refugees speak little or no English. Language difficulties increase the risk that assessment procedures that depend on verbal or written communication will be inaccurate. Miscommunication can occur even with the use of a translator however, because the bilingual interprter must translate the questions into a language that may not contain corresponding words. In Asian cultures, few words exist for psychological problems. Interpreters may also be influenced by the

cultural norms and values to which they adhere and may hesitate to reveal certain symptoms that might be viewed negatively by the community. They have reported reluctance to ask about sexual matters, financial background, material considered to be disrespectful to the therapist, and information related to suicide or homicidal thoughts (Sue & Sue, 1987). In a study on the effects of interpreters on the evaluation of psychopathology in non-English speaking patients, Marcos (1979) found three major forms of distortions by Chinese- and Spanish-speaking interpreters. The first involved ommisions, substitutions, condensation, and change of focus:

> Clinician to Chinese-speaking patient: "What kind of moods have you been recently?"
> Interpreter to patient: "How have you been feeling?"
> Patient's response: "No, I don't have any more pain, my stomatch is fine, and I can eat much better since I take the medication."
> Interprter to clinician: "He says that he feels fine, no problem."

In this example, the interpreter did not focus on the moods and left out information that might have been valuable. A second possible distortion involves a lack of psychiatric knowledge on the part of the interprter. In these cases, the interpreter tends to normalize the patient's thought processes and descriptions or tries to make sense of disorganized statements, thus preventing the clinician's attempt to gain a clear idea of the patien's mental status.

With all the limitations due to cultural influences in the clinical assessment of Asian-Americans, what should be done to minimize misdiagnoses and maximize benefits to the population? If the aim of diagnosis is to direct differential treatment goals and educational

planning for individuals, rather than limit intervention or justify inadequate resources, as suggested by Chin (1983), diagnosis should move from trait and typology delineation toward a process of being a tool for intervention, and understand cultural views and values as they affect the differential models of adaptation as well as the development of cognitive and emotional skills. In order to understand cultural groups in our society, it is important to adopt a mutifactor, pluralistic approach. Clinicians need to consistently evaluate diagnositic construct from a muti-cultural perspective, identifying constructs that may be relevant in a specific therapeutic/diagnositic situation. Once these constructs have been identified, it is important to assess the situation within the context of the client's cultural background, utilizing all available information in an attept to understand how the client's culture construes and experiences the construct (Sue & Sue, 1987).

References:

Abel, T. & Hsu, F. (1949). Some aspects of Chinese as revealed by the Rorschach test. Journal of Projective Techniques, 13, 285-301.

Brinslin, R. W., Lonner, W., & Thorndike, R. (1973). Cross-cultural research methods. New York: Wiley.

Chin, J. L. (1983). Diagnostic considerations in working with Asian-Americans. American Journal of Orthopsychiat, 53(1), 100-109.

Cook, T. (1942). The application of Rorschach test to a Samoan group. Journal of Projective Techniques, 6, 51-60.

Marcos, L. R. (1979). Effects of interpreters on the evaluation of

psychopathology in non-English speaking patients. American Journal of Psychiatry, 136, 171-174.

Pang, V. O. (1990). Asian-American Children. The Educational Forum, 55(1), 49-66.

Satter, J. M. (1988). Assessment of children. San Diego: Jerome M. Satter.

Sue, D. W. (1981). Conseling the culturally different: Theory & practice. New York: Wiley.

Sue, D. & Sue, S. (1987). Cultural factors in the clinical assessment of Asian Americans. Journal of Consulting and Clinical Psychology, 55(4), 479-487.

Westermeyer, J. (1987). Cultural factors in clinical assessment. Journal of Consulting and Clinical Psychology, 55(4), 471-478.

White, W. G. & Chan, E. (1983). A comparison of self-concept scores of Chinese and White graduate students and professionals. Journal of Non-White Concerns, 19,138-141.